Received on 11/13/07

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FORM APPROVED
OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	09G183	A. BUILDING _____ B. WING _____	10/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MTS	4414-16 JAY STREET, NE WASHINGTON, DC 20019

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W 000	INITIAL COMMENTS A recertification survey was conducted from October 16, 2007 thru October 18, 2007. The survey was initiated using the full survey process. A random sample of three clients was selected from a resident population of four females and one male with various disabilities. A fourth client was added for a focused review in healthcare. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	W 000		
W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met for two of three clients included in the sample. (Client #2 and #3) The findings include: The facility failed to ensure that Client #2 and #3 received the appropriate adaptive feeding equipment during lunch time at the day program as evidence below: 1. Observations conducted during lunch time on 10/16/07 at approximately 12:26 PM revealed that Client #2 was served her prescribed pureed diet with double portions in a round built-up plate. Further observations revealed that the client used	W 120	W120 1. MTS will purchase the needed items for client #2 and provide them to the day program by 11-15-07. This will be at least the second set given to the program. The QMRP will visit the program at minimum monthly to ensure that the program has and uses the adaptive feeding equipment supplied for client #2 routinely.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Residential Program Asst. 11/13/07

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W 120	483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES The facility must assure that outside services meet the needs of each client. This STANDARD is not met as evidenced by: Based on observations, staff interview, and record review, the facility failed to effectively monitor each client's day program to assure that the needs were met for two of three clients included in the sample. (Client #2 and #3) The findings include: The facility failed to ensure that Client #2 and #3 received the appropriate adaptive feeding equipment during lunch time at the day program as evidence below: 1. Observations conducted during lunch time on 10/16/07 at approximately 12:26 PM revealed that Client #2 was served her prescribed pureed diet with double portions in a round built-up plate. Further observations revealed that the client used	W 120	W120 1. MTS will purchase the needed items for client #2 and provide them to the day program by 11-15-07. This will be at least the second set given to the program. The QMRP will visit the program at minimum monthly to ensure that the program has and uses the adaptive feeding equipment supplied for client #2 routinely.	

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W 120	Continued From page 1 a coated tablespoon to consume her meal. In an earlier interview with the day program at approximately 11:25 AM, it was revealed that Client #2 feeds herself independently using a coated tablespoon and Dycem mat as needed. Further interview with the day program staff revealed that Client #2 was prescribed a pureed diet with double portions. Review of the Individual Support Plan (ISP) dated 6/25/07 on 10/17/07 at approximately 12:00 PM revealed that Client #2's adaptive equipment included a built-up weight spoon, divided scoop plate, and a wonder flow cup during mealtime. Review of the Occupational Therapist Assessment Addendum dated 1/7/07 recommended that Client #2 could benefit from a sectional divided plate to increase independence, Dycem mat, weight built-up spoon, and spout cup. There was no evidence Client #2 used sectional divided plate, built-up weight spoon, or drank from a spout cup as recommended by the ISP/OT in the day program. 2. Observations conducted during lunch time on 10/16/07 at approximately 11:40 PM revealed that Client #3 was served a prescribed regular ground diet. Further observations revealed that the Client #2 drank two apple juices, two chocolate milks, and water from a blue mug with a small skinny straw independently. In an earlier interview with the day program's Adult Coordinator (AD) at approximately 10:47 AM, it was revealed that Client #3 likes the blue mug. The AD also revealed that the client can hold the mug and consume his liquids independently. Review of the Occupational Therapist (OT) Assessment Addendum dated 1/10/07 on 10/17/07 at approximately 2:47 PM recommended that Client #3 could benefit from a plate riser, Dycem mat, right handed curved	W 120	2. Both the day program and home will use a cup with straw as the best option for #3. The day program uses the cup with straw now. The home will switch to cup with straw by 11/15/07. The staff will be trained on cup/straw method for Client # 3 by 11-20-07.	

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W 120	Continued From page 2 spoon, and nosey cup to increase drinking efficiency. Interview with the OT on the same day at 3:00 PM revealed that "the blue mug with the straw used at the day program and recommended nosey cup serves the same purpose; however, we need to narrow it down and use one cup consistently".	W 120		
W 124	483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARD is not met as evidenced by: Based on observation, Interview and record verification, the facility failed to ensure the right of each client or their legal guardian to be informed of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and the right to refuse treatment for two of four clients in the sample. (Client #2 and Client #3) The findings include: 1. Observation of the morning medication administration on October 16, 2007 at approximately 7:55 AM, revealed Client #2 received Fluoxetine HCL 40 mg and Naltrexone Hydrochloride 50 mg (1/2/ tab BID) by mouth. Interview with the nursing staff on October 16, 2007 at approximately 7:58 AM revealed that the medications were prescribed for behavior	W 124	W124 Client # 2's mother has agreed to provide consent and has been given the appropriate paperwork to do so, and provide consent for the BSP and drug regimen. The QMRP will obtain the signed documents by 11-15-07.	

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W 124	Continued From page 3 management. Review of the client's physicians orders dated October 2007 on October 16 2007 at approximately 10:10 AM revealed that Fluoxetine HCL 40 mg by mouth every morning and Naltrexone Hydrochloride 50 mg (1/2/ tab) by mouth twice a day was incorporated in a Behavior Support Plan (BSP) dated June 13, 2007, to address behaviors associated with hand mouthing and finger sucking, and head dropping/banging. Interview with the Qualified Mental Retardation Professional (QMRP) on October 16, 2007 at approximately 10:15 AM revealed that Client #2 did not have a legal guardian. Further interview revealed that Client #3's mother signs the consents for her medical procedures, however she was not the client's legal guardian. The review of Client #2's Psychological Assessment dated June 13, 2007 on October 17, 2007 at approximately 12:00 PM indicated that the client was not competent to make independent decisions concerning her residential or day program placements, treatment plan or financial affairs. There was no documented evidence that the facility informed Client #2 or a legally authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of her psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity. 2. Observation of the morning medication administration on October 16, 2007 at approximately 7:45 AM, revealed Client #3 received Risperdal 1 mg and Clonazepam 0.5 mg by mouth. Interview with the nursing staff on	W 124		

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W 124	Continued From page 4 October 16, 2007 at approximately 7:50 AM revealed that the medications were prescribed for behavior management. Review of the client's physicians orders dated September 28, 2007 on October 16 2007 at approximately 10:00 AM revealed that Risperdal 1 mg by mouth twice a day and Clonazepam 0.5 mg by mouth twice a day was incorporated in a Behavior Support Plan (BSP) dated July 1, 2007, to address behaviors associated with physical aggression (i.e. hitting, kicking or grabbing others) and non-compliance. Interview with the Qualified Mental Retardation Professional (QMRP) on October 16, 2007 at approximately 10:15 AM revealed that Client #3 did not have a legal guardian. Further interview revealed that Client #3's sister signs the consents for his medical procedures, however she was not the client's legal guardian. The review of Client #3's Psychological Assessment dated July 1, 2007, on October 16, 2007 at approximately 10:45 AM indicated that the client was not competent to make independent or informed decisions concerning medical and psychological treatment. There was no documented evidence that the facility informed Client #3 or a legally authorized representative, as appropriate, of the health benefits and risks of treatment associated with the use of his psychotropic medications and corresponding BSP. Additionally, the facility failed to provide evidence that substituted consent had been obtained from a legally recognized individual or entity.	W 124	Client #3's sister has already signed consent forms and forms establishing her as the primary decision-making support person. 11-1-07. (see Attached copies). Both relatives will be contacted and informed consistently on consent issues and prior consent will be obtained for each for all necessary issues.	
W 153	483.420(d)(2) STAFF TREATMENT OF CLIENTS The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as	W 153		

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W 153	Continued From page 5 Injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established proceduros. This STANDARD is not met as evidenced by: Based on interview and record review, report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section 3519.10). The findings include: 1. Review of an unusual incident report dated 3/21/07 on 10/16/07 at approximately 9:05 AM revealed that Client #2 had a seizure while sitting in her wheelchair at the day program. Further review of the incident revealed the client dropped her head an injured her right eyebrow and was taken to the emergency room. The client was diagnosed with an abrasion to the eyelid and contusion to the right eye. There was no documented evidence that this incident had been reported to governmental agencies as required. 2. Review of an unusual incident report dated February 5, 2007 on October 16, 2007 at approximately 9:05 AM revealed that Client #1 was transported to the hospital emergency room for vomiting coffee ground material and was subsequently admitted for gastric intestinal bleeding. There was no evidence that this incident was reported to the DOH until February 12, 2007. 3. Review of an unusual incident report dated	W 153	W153 1. The day program involved does not routinely send incident reports to MTS or any other residential providers. They say their obligation is to send such reports to the DDS case manager. MTS will meet with the day program to ensure that the program agrees to send such incident reports to the MTS home within 24 hours, so that it can be submitted to DOH and filed by MTS or that they send them to DOH and MTS in addition to DDS case manager. MTS will involve DDS case manager to ensure an agreement is reached. 2. The facility failed to send the incident report for client #1 to the IMC in a timely manner in this case. The QMRP will retrain all staff to ensure that each understands that incident reports must be sent to the IMC by the end of the shift on which the incident occurs. 3. See response for #2 above.	

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W 153	Continued From page 6 February 28, 2007 on October 16, 2007 at approximately 9:15 AM revealed that Client #3 was transported to the hospital emergency room for evaluation of a superficial burn on the right side of his neck. There was no evidence that this incident was reported to the DOH until February 4, 2007.	W 153		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Based on interview and review of medical records the facility failed to document the provision of thorough investigations of injuries of unknown origin for the one of four clients in the sample. (Client #3) The findings include: 1. Review of an unusual incident report dated February 28, 2007 on October 16, 2007 at approximately 9:15 AM revealed that Client #3 was transported to the hospital emergency room for evaluation of a superficial burn on the right side of his neck of unknown origin. Interview and record review on October 16, 2007 at approximately 9:25 AM revealed an undated investigative report on Client #3's injury. There was no documented evidence when this investigation was conducted by the facility.	W 154	W154 The incident investigation was completed by the home's QMRP at that time but was not properly signed off. The Residential Director will review all such incidents in the future before they are finalized to ensure they are full and complete, including being properly signed off.	
W 159	483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a	W 159		

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W 159	Continued From page 7 qualified mental retardation professional. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to integrate, coordinate and monitor its clients active treatment programs. The findings include: 1. Cross refer to W120. The QMRP failed to ensure that Client #2 and #3 received the appropriate adaptive feeding equipment during lunch time at the day program. 2. Cross refer to W189. The QMRP failed to ensure that failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties. 3. Cross refer to W436. The QMRP failed to ensure that Client #1's wheelchair was in good repair. 4. Cross refer to W436. The QMRP failed to ensure that clients were provided with necessary adaptive equipment. 5. Cross refer to W220. The QMRP failed to inform the Interdisciplinary Team (IDT) to ensure that Client #4 had a speech/ language assessment as recommended by the incident management coordinator. 6. The QMRP failed to ensure that staff monitored Client #3 every half hour during the	W 159	W159 1. See W120 2. See W189 3. See W436 4. See W436 5. See W220	

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W 159	Continued From page 8 night as evidenced by: Review of an unusual incident report dated February 28, 2007 on October 16, 2007 at approximately 9:15 AM revealed that Client #3 was transported to the hospital emergency room for evaluation of a superficial burn on the right side of his neck of unknown origin. Review of an undated investigative report regarding this incident revealed that the injury occurred when Client #3's head was caught between the bed railing and the wall during the night. Further review revealed a recommendation that staff monitor Client #3 every half hour during the night. In an interview with the QMRP on October 17, 2007 at approximately 3:25 PM it was acknowledged that the staff were not documenting bed checks every half hour on Client #3. There was no documented evidence that Client #3 was being monitored every half hour during the night. 7. The QMRP failed to ensure that Client#1 was provided a plate riser as recommended by the Occupational Therapist (OT) as evidenced by: Breakfast observation on October 16, 2007 at approximately 6:40 AM, revealed that the staff placed three divided plates on top of each other in order to elevate Client#1's plate. Interview with direct care staff on October 16, 2007 at approximately 6:50 AM, revealed that Client #1 did not have a plate riser. Review of the OT assessment dated January 10, 2007 on October 17, 2007 at approximately 1:15 PM, revealed that Client #1 was to be provided a plate riser to modify her feeding environment and increase overall independence in self feeding. There was no evidence that a plate riser was provided as	W 159	6. The QMRP discussed the recommendation for client #3 to monitor him every ½ hour overnight. Both agreed that this was too intrusive and unnecessary. They agreed that hourly checks would be both more appropriate and sufficient. The QMRP and RN will collaborate on a form for collecting data hourly and will train staff on it's implementation by 11-15-07. 7. Client #1's plate Riser will be obtained by 11-15-07. The QMRP will develop a checklist of the recommendations accepted by the team from each clinical service and for each person supported. This checklist will be used to track recommendations and ensure all are properly implemented.	

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W 159	Continued From page 9 recommended by the OT. 8. The QMRP failed to ensure that Client#1 was provided adult hobby materials as recommended by the Psychologist as evidenced by: Evening observation on October 16, 2007 at approximately 4:45 PM, revealed that the staff assisted Client#1 in playing with a child age key board. Review of the psychological assessment dated June 10, 2007 on October 17, 2007 at approximately 12:10PM, revealed that Client #1 was to be provided adult hobby materials that made noise. In an interview with the QMRP on October 17, 2007 at approximately 1:20 PM it was acknowledged that Client #1 did not have adult hobby materials that made noise . There was no evidence that adult hobby materials that made noise were provided as recommended by the Psychologist . [Note: The QMRP brought adult hobby materials for Client #1 on October 18, 2007] 9. The QMRP failed to ensure that Client #1 was provided prune juice and cranberry juice as recommended by the nutritionist as evidenced by: Breakfast observation on October 16, 2007 at approximately 6:40 AM, revealed that the staff served Client #1 apple juice. Review of the Primary Care Physicians orders dated September 28, 2007 revealed that Client #1 was to have prune juice two to three times a week and cranberry juice three times a week. Environmental observation on October 17, 2007 at approximately 9:40 AM revealed that there was no prune juice and cranberry juice in the facility.	W 159	8. See Response for #7 above. In addition, the QMRP will ensure that adult hobby materials are replenished as needed. 9. The QMRP will retrain staff on shopping according to the planned menus. 11-20-07. In addition the facility manger will check the food and drink supplies on a weekly basis (Mondays) to ensure that all items planned for all of the week's meals are in adequate supply.	

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W 159	Continued From page 10 In an interview with the QMRP on October 17, 2007 at approximately 9:45 AM it was acknowledged that the facility did not have prune juice and cranberry juice in the facility. There was no evidence that prune juice and cranberry juice was provided as recommended by the nutritionist. [Note: The QMRP provided prune juice and cranberry juice for Client #1 on October 18, 2007]	W 159		
W 170	483.430(b)(5) PROFESSIONAL PROGRAM SERVICES Professional program staff must be licensed, certified, or registered, as applicable, to provide professional services by the State in which he or she practices. This STANDARD is not met as evidenced by: Based on staff interview and record review, the facility failed to ensure that all professionals are licensed and/or certified in accordance with the District of Columbia Laws. The finding include: The review of personnel records on October 18, 2007, at approximately 10:40 AM indicated that the professional licenses for the Podiatrist, Recreational Therapist and Pharmacist were not available for review. There was no evidence that the Podiatrist, Recreational Therapist and Pharmacist were currently licensed in accordance with the Health Occupation Revision Act (HORA), Title 3 Chapter 12, Section 3-1205.13 ("Each licensee shall display the license conspicuously in any and all places of business or employment of the licensee.")	W 170	W170 MTS does not use a recreation Therapist. MTS will obtain copies of the Podiatrist's license and that of the Pharmacist's. Both will be obtained by 11-15-07. MTS has audited it's entire set of personnel files for it's clinical professionals and has notified each person with a file deficiency or several as to what is needed. All are responding by submitting the requested materials. All should be at 100% by 11-30-07. MTS will continue to track these often and will proactively notify staff of upcoming personnel file issues.	
W 189	483.430(e)(1) STAFF TRAINING PROGRAM	W 189		

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W 189	Continued From page 11 The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that each employee had been provided with adequate training that enables the employees to perform his or her duties effectively, efficiently and competently. The findings include: 1. Observations conducted during snack time on 10/16/07 at approximately 4:34 PM revealed Client #2 eating vanilla pudding independently with some difficulty using her right hand. The client was further observed to have a mitten on her right hand while feeding. Interview with the Qualified Mental Retardation Professional (QMRP) on 10/18/07 at approximately 11:49 AM revealed that Client #'s mittens can be on or off while feeding. Review of Client #2's Occupational Therapy (OT) Addendum dated 1/7/07 recommended that the hand mitten be on the left hand when performing self-feeding tasks. At no time during the survey was staff observed to remove the hand mitten from Client #2's right hand to the left hand as recommended. 2. Cross Refer to W460. The facility failed to ensure that staff had received effective training on Client #3's food allergies.	W 189	W189 1. QMRP will retrain staff to ensure that client #2's mitten is removed from her right hand during meals. The QMRP will observe at minimum one meal weekly to ensure routine compliance. 2. See response for W460	
W 192	483.430(e)(2) STAFF TRAINING PROGRAM	W 192		

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W 192	Continued From page 12 For employees who work with clients, training must focus on skills and competencies directed toward clients' health needs. This STANDARD is not met as evidenced by. Based on observation, staff interview and record review, the facility failed to effectively train staff to implement emergency measures for five of five clients in the facility. (Clients #1, #2, #3 and #4) The findings include: 1. The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for five of five clients in the facility as evidenced by: Interview with the House Manager on October 18, 2007 at approximately 10:00 AM revealed that all staff was not trained in CPR. Record review on October 18, 2007 at approximately 10:10 AM revealed that three out of ten staff did not have current CPR certifications. There was no documented evidence that all direct care staff had CPR training and current CPR certifications. 2. The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for five of five clients in the facility as evidenced by: In an interview with the House Manager on October 18, 2007 at approximately 10:05 AM acknowledged that all staff was not trained in First Aid. Record review on June 25, 2007 at approximately 10:15 AM revealed that three out of ten staff did not have current First Aid	W 192	W192 1. All ten staff have current CPR certification and training including the three cited, but MTS has not yet received the cards from the training agent. The training was done in September 2007. MTS will obtain the cards by 11-30-07. A signature sheet and agenda are attached as proof of the training. 2. See response for # 1 above.	

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W 192	Continued From page 13 certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications.	W 192		
W 220	483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include speech and language development. This STANDARD is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the provision of a recommended speech and language assessment for two of four clients in the sample. (Client #1 and #4) The finding includes: 1. Breakfast observation on October 16, 2007 at approximately 6:40 AM, revealed that Client # 1was observed eating her food with a left handed curved built-up spoon at a fast pace . Staff verbally prompted the client to slow down and the client complied by slowing down her eating pace. Review of Client #1's physicians's orders dated September 28, 2007 at approximately 11:45 AM on October 17, 2007 revealed that she has a diagnosis of spastic quadriplegia. Medical record review on October 17, 2007 at approximately 11:50 AM revealed that Client #1 did not have a speech/ language assessment. In an interview with the Qualified Mental Retardation Professional (QMRP) on October 17, 2007 at 11:55 AM it was acknowledged that Client #1 did not have a speech/ language assessment. There was no documented evidence that the client had been assessed by the speech/ language therapist.	W 220	W220 1. Client #1 does have a speech assessment that was filed under speech Assessment that was filed under "Speech Pathology" in the ISP book. (see attached copy)	

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W 220	Continued From page 14 2. Review of an undated investigative report on October 16, 2007 at approximately 9:25 AM revealed that on June 1, 2007, Client # 4 was transported to the hospital emergency room and admitted for right lower lobe pneumonia and discharged on June 4, 2007. Further review revealed a recommendation for Client # 4 to be evaluated by the speech/ language therapist to rule out dysphasia and associated aspiration of food, thin liquids and salvia. In an interview with the QMRP on October 17, 2007 at 3:55 PM it was acknowledged that Client #4 did not have a speech/ language assessment completed. There was no documented evidence that the client had been assessed by the speech/ language therapist.	W 220	2. Client #4 is scheduled to have a swallowing study done on 11-12-07. Client #1 is also scheduled for a swallow study on 11-09-07. The dysphasia issue will be addressed at that time.	
W 231	483.440(c)(4)(iii) INDIVIDUAL PROGRAM PLAN The objectives of the individual program plan must be expressed in behavioral terms that provide measurable indices of performance. This STANDARD is not met as evidenced by: Based on interview and record review the facility failed to ensure that all client program objectives were formulated to provide measurable indices of performance for two of four clients in the sample. (Client #1 and #3) The findings include: 1. Review of Client #1's Individual Program Plan (IPP) dated October 2007, on October 17, 2007 at approximately 1:50 PM included the following money management objective: a. Select an item b. Take item to the cashier	W 231	W231 The QMRP did not acknowledge that the money management objective for client #1 and #3 "had multiple criteria for mastery and was not measurable." To the contrary, the QMRP does not agree client #1's measurable objective in the money management area is, "_____will make a small purchase in the community once a month for six months consecutive months." That objective is measurable. Items "a" through "f" referred to by the surveyor are the functional steps that must be completed to successfully complete the task. The surveyor seems to be confusing "multiple criteria for mastery" with task analysis breakdown. Plus (+) or (-) is used as opposed to levels of assistance (Physical, gestural, verbal, Independent) because the QMRP and IDT recognizes that client #1 will always need physical assistance to make a purchase, along with one-on-one staff support and guidance.	

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W 231	Continued From page 15 c. Pay for item e. Wait for the change/receipt f. Say thank you Further review of the objectives indicated that the staff was instructed to document a (+) for accomplished if all five objectives were completed and (-) if all five objectives were not met or refused. In an interview with the Qualified Mental Retardation Professional (QMRP) on October 18, 2007 at approximately 2:00 PM it was acknowledged that the program had multiple criteria for mastery and was not measurable. There was no evidence that the measurement criteria provided measurable indices of performance at each level. 2. Review of Client #3's Individual Program Plan (IPP) dated 8/20/0, on October 18, 2007 at approximately 9:36 AM included the following money management objective: a. Select an item b. Take item to the cashier c. Pay for item e. Wait for the change/receipt f. Say thank you Further review of the objectives indicated that the staff was instructed to document a (+) for accomplished if all five objectives were completed and (-) if all five objectives were not met or refused. In an interview with the Qualified Mental Retardation Professional (QMRP) on October 18, 2007 at approximately 2:00 PM it was acknowledged that the program had multiple criteria for mastery and was not measurable. There was no evidence that the measurement criteria provided measurable indices of	W 231	The objective then aims to measure her level of participation and coorperation. Staff is instructed to score plus(+) if she -Accepts assistance -Follows instructions -coorperates/participates fully. For each step and minus (-) if she does not, staff understand this fully and explained it to the monitor when asked. Client #3's objective is also measurable, " _____ will make a small purchase of no more than one dollar from his personal funds given no more than 3 verbal cues from staff on 6 consecutive opportunities presented." Again there are task analyzed steps but in this case, the level of assistance is measured: A= needed hands on assistance R= Verbal Reminder X= Given opportunity did not perform G= gestural assistance I= Independence In october, client #3 performed at the "A" level for all steps.(Needed hands on assistance). The QA consultant will meet with the QMRP to review these programs and those cited under W237 to insure that they are clearly stated in measurable terms, and data collection system and task analysis reflect the measurable objective and that there are clear protocols for staff to follow that explain all of the above.	

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W 231	Continued From page 16 performance at each level	W 231		
W 237	483.440(c)(5)(iv) INDIVIDUAL PROGRAM PLAN Each written training program designed to implement the objectives in the individual program plan must specify the type of data and frequency of data collection necessary to be able to assess progress toward the desired objectives. This STANDARD is not met as evidenced by: Based on record review, the facility failed to ensure that each written training program designed to implement the objectives in the individual program plan (IPP) specified the type of data necessary to assess progress toward the desired objective for one of the three clients in the sample. (Client #2) The finding includes: 1. Review of Client #2's Individual Programs Plan (IPP) and data collection on 10/17/07 at approximately 12:00 PM revealed the following objectives: a. Given Physical Assistance (PA), the client will tolerate dance for 20 minutes for 50% of the opportunities for 2 consecutive months. b. Given PA, the client will place her dirty clothes in her clothes hamper with 50% of the opportunities for 2 consecutive months c. Given PA, the client will complete all steps of the hand washing process 50% of the opportunities for six consecutive months. 1. Turn on water	W 237	W237 See Responses for W231 above. In addition, it must be recognized that training objectives are sometimes run when it is known that the person will not reach independence for that objective. The goal in such cases is to train the person to their maximum performance level whatever that might be. Licensure itself has pushed for such training in the money management area and self medication and MTS agrees with that philosophy. When the QMRP indicates "given Physical assistance" for particular objectives it is because the IDT has recognized that the person will continually need that level of assistance but can be trained to Accept that support and coorperate/participate fully. That is what is being measured for such objectives and that is why the plus(+) or minus(-) legend is most appropriate.	

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W 237	Continued From page 17 2. Rinse/wet hands 3. Put soap on hands 4. Lather hands with soap 5. Rinse hands 6. Pull paper towel off the roll 7. Dry hands 8. Turn of water According to the data sheets, staffs' documented a (+) if the client completed the task and (-) if the client did not complete the tasks or refused. The data sheet did not reflect at what level of assistance was being used. It could not be determined how these goals were being measured for progress. Interview with the Qualified Mental Retardation Professional (QMRP) on 10/18/07 at approximately 1:45 PM acknowledged that the current data collection system did not provide accurate measurement the client's progress. 2. Review of Client #3's Individual Programs Plan (IPP) and data collection on 10/17/07 at approximately 1:50 PM revealed the following objectives: a. The client will learn to count to sixty given verbal/physical prompts at 70% accuracy 2 times a week for 6 consecutive months. b. The client will learn to tell time by the hour given verbal/physical prompts at 60% accuracy twice a week for 6 months. c. Will participate in small group activities taking turns 2 times a week for 45 minutes on task 100% of the time with independence.	W 237		

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W 237	Continued From page 18 d Will brush his teeth daily in the AM/PM and at the day program with verbal prompts at 70% accuracy for 6 consecutive months. e. Will make a small purchase involving not more than one $1.00 dollar of his personal funds given no more than 3 verbal cues for six months. According to the data sheets, staffs' documented a (+) if the client completed the task and (-) if the client did not complete the tasks or refused. The data sheet did not reflect at what level of assistance was being used. It could not be determined how these goals were being measured for progress. Interview with the Qualified Mental Retardation Professional (QMRP) on 10/18/07 at approximately 1:45 PM acknowledged that the current data collection system did not provide accurate measurement the client's progress.	W 237		
W 255	483.440(f)(1)(i) PROGRAM MONITORING & CHANGE The individual program plan must be reviewed at least by the qualified mental retardation professional and revised as necessary, including, but not limited to situations in which the client has successfully completed an objective or objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Based on record review, the Qualified Mental Retardation Professional (QMRP) failed to revise objectives identified in the individual program plans (IPPs)as they had been successfully achieved for one of four clients included the sample. (Client #2)	W 255		

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W 255	Continued From page 19 The finding includes: Review of the Client #2's Individual Program Plans (IPP)s and related data collection was reviewed on 10/18/07 at approximately 8:44 AM. There were no revisions made to the program that had been achieved at the stated criterion level as evidenced below: Client #2's IPP indicated that the client will tolerate ten (10) repetitions of shoulder/elbow passive Range of Motion (ROM) on 80% of the trials recorded per month for 3 consecutive months. The documentation reflected that from June 2007 to September 2007, the client performed at tasks above 80% . Interviews with the Qualified Mental Retardation Professional (QMRP) on 10/18/07 at approximately 11:49 AM acknowledged that the client had achieved the objective according to the stated criterion. There was no document evidence that the QMRP discontinued the program after the criterion was met.	W 255	W255 Client #2 achieved the cited objective in September of 2007. The QMRP discontinued the program at that time. However, as is often done, the QMRP had staff collect data for another month (October) to ensure that the skill level achieved was retained. It was. Data collection was totally discontinued as of November 2007. Client #2 continues to perform the task as a structured activity.	
W 263	483.440(f)(3)(ii) PROGRAM MONITORING & CHANGE The committee should insure that these programs are conducted only with the written informed consent of the client, parents (if the client is a minor) or legal guardian. This STANDARD is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to ensure that each client's behavior intervention technique, including the use of behavior modification drugs was conducted with the written informed consent of	W 263		

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W 263	Continued From page 20 the client, parents (if the client is a minor) or legal guardian for two of two clients in the sample (Client #2 and Client #3). The findings include: Cross refer to W124. There was no evidence that written consent had been obtained for Client #2 and Client #3's Behavior Support Plans (BSPs) and for the use of their prescribed psychotropic medications. Interview with Qualified Mental Retardation Professional (QMRP) on October 16, 2007 at approximately 12:30 PM revealed that Client #2 and #3 did not have written informed consents signed by a guardian or legally recognized individual or entity.	W 263	W263 See Responses for W124	
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Based on observation, interviews, and record review, the facility failed to ensure that nursing services were provided in accordance with clients needs for one of four clients in the sample (Client #2). The finding includes: The facility's nursing staff failed to ensure that Client #2's Seizure Activity Summary Log was documented monthly as evidenced below: During the medication administration observed on 10/16/07 at approximately 7:55 AM, Client #2 was administered Dilantin (Chewable) 50 mg and Keppra 500 mg for seizures. Review of the	W 331		

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W 331	Continued From page 21 current Physician's Orders on 10/17/07 at approximately 8:50 AM revealed that the client had a diagnosis of Seizure Disorder. Further review of the Client #2's medical book revealed a "Seizure Activity Summary Log". According to the seizure activity summary log, Client #2 had zero (0) seizures for the months of July 2007 and August 2007. Review of the nursing notes and Epilepsy Management for persons with Mental Retardation on the same day at approximately 3:37 PM revealed that Client #2 had a seizure on 7/12/07 that last for two minutes and 8/16/07 while sleeping. Interview with the Licensed Practical Nurse (LPN) on 10/18/07 at approximately 1:50 PM revealed that Client #2 has seizures and that the direct care staff fills out the seizure forms. Further interview with the LPN revealed that the nurses's review the seizure forms and document the seizure activity in the Seizure Activity Summary Log monthly. There was no evidence that the seizures were being documented as indicated by the LPN.	W 331	W331 The Facility Manager purged the August 2007 and July 2007 logs without consulting the QMRP. The QMRP has followed up formally. 11-7-07 The August and July logs will be reconstructed using the nursing notes and staff progress notes to ensure that the record is full and complete.	
W 436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. This STANDARD is not met as evidenced by: Based on observations, interview and record review, the facility failed to ensure that clients were provided with necessary adaptive equipment for two of the four clients included in the sample. (Client #1 and Client #3)	W 436		

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W 436	Continued From page 22 The finding includes: 1. The facility failed to ensure that Client #3 was provided the necessary adaptive equipment as evidenced below: 1a. Observations conducted at the day program and group home on 10/16/07 revealed Client #3 used a basic wheelchair for mobility. Review of Client #3's Individual Support Plan (ISP) dated 8/20/07 on 10/17/07 at approximately 1:50 PM revealed a Physical Therapist Assessment (PT) dated 8/23/06. According to the PT assessment, it was recommended that Client #3 receive a new "Quicy Iris Custom Molded Wheelchair". Interview with the facility's Registered Nurse (RN) on 10/18/07 at approximately 2:00 PM revealed that the facility had put in several requests for the recommended wheelchair back in February 2007, March 2007, May 2007, and July 2007. The RN further revealed that the facility had purchased a new basic wheelchair in June 2007 to prevent Client #3 from being discharged from his day program. At the time of the survey, there was no evidence that the client had received custom molded wheelchair as recommended as recommended in the ISP. b. Review of Client #3's Individual Support Plan (ISP) dated 8/20/07 on 10/17/07 at approximately 1:50 PM revealed a Mobility Evaluation (ME) dated 1/9/07. The ME recommended a wrist and elbow comfy splint for contractures. Interview with the QMRP on 10/18/07 at approximately 11:49 AM revealed that she was not aware of the recommendations for the adaptive equipment. The QMRP further revealed that the wrist and elbow comfy splint had not been purchased. At	W 436	W436 1A. MTS has submitted all of the necessary paperwork for client #3's custom molded wheelchair once again(October 2007). Essential Rehab was to come out and measure client #3 on October 29, 2007 but did not. The RN and QMRP are pursuing a rescheduled date but will submit the information to an alternative vendor for processing if this is not resolved by 11-20-07. B. Client #3's splint has been ordered and should be received by 11-15-07. The QMRP will ensure that adaptive equipment needs are indicated on the nursing Health Management Care Plans so as to track follow-up effectively. See Also responses for W159 (item#7).	

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W 436	Continued From page 23 the time of the survey, there was no evidence that the client had received the recommended adaptive equipment. 2. The facility failed to ensure that Client #1's wheelchair was in good repair was as evidenced below: On October 16, 2007 at approximately 7:00 AM , the right armrest on Client #1's wheelchair was observed to be torn in several places.	W 436	2. The armrest of client #1's wheelchair will be replaced by 11-30-07. The QMRP and RN separately will Audit adaptive equipment monthly to ensure all is in adequate supply and in good repair. 11-30-07.	
W 460	483.460(a)(1) FOOD AND NUTRITION SERVICES Each client must receive a nourishing, well-balanced diet including modified and specially-prescribed diets. This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure therapeutic diets addressed the nutritional needs of one of the four clients in the sample. (Client # 3) The finding includes: Dinner preparation observed on October 16, 2007 at approximately 4:00 PM revealed that the facility's main entree was ground turkey with tomatoes sauce. Interview with the House Manager on October 17, 2007 at approximately 1:00 PM revealed that Client # 3 was served the main entree of ground turkey with tomato sauce on October 16, 2007. Review of the Primary Care Physician's (PCP) orders dated February 2007 on October 17, 2007 at approximately 1:25 PM revealed that Client #3 was allergic to tomatoes and tomatoes based products. Review of the	W 460	W460 The nutritionist will retrain staff on the diets and diet restrictions of all of the individuals supported by 11-20-07. The QMRP and facility manager will observe meals at minimum one weelky(QMRP0 or twice weekly (Facility manager) to ensure routine compliance. 11-15-07 In addition, the nutritionist will supply menu substitutions for all excluded foods/drinks by 11-15-07.	

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W 460	Continued From page 24 facility's menu book on October 18, 2007 at approximately 1:30 PM revealed that there were no substitute menus for the staff to use when tomatoes or tomatoes based products where on the menu. In an interview with the House Manager it was acknowledged that the facility did not have substitute menus for Client # 3. There was no evidence that the nutritionist provided the facility with substitute menus for Client # 3.	W 460		

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I 000	INITIAL COMMENTS A licensure survey was conducted from October 16, 2007 thru October 18, 2007. The survey was initiated using the full survey process. A random sample of three clients was selected from a resident population of four females and one male with various disabilities. A fourth client was added for a focused review in healthcare———. The findings of the survey were based on observations, interviews with staff in the home and at two day programs, as well as a review of client and administrative records, including incident reports.	I 000		
I 057	3502.16 MEAL SERVICE / DINING AREAS Menus shall be written on a weekly basis, shall provide a variety of foods at each meal, and be varied from week to week and adjusted for seasonal changes. This Statute is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure therapeutic diets addressed the nutritional needs of one of the four residents in the sample. (Resident # 3) The finding includes: Dinner preparation observed on October 16, 2007 at approximately 4:00 PM revealed that the facility's main entree was ground turkey with tomatoes sauce. Interview with the House Manager on October 17, 2007 at approximately 1:00 PM revealed that Resident # 3 was served the main entree of ground turkey with tomato sauce on October 16, 2007. Review of the Primary Care Physician's (PCP) orders dated February 2007 on October 17, 2007 at	I 057	W460 The nutritionist will retrain staff on the diets and diet restrictions of all of the individuals supported by 11-20-07. The QMRP and facility manager will observe meals at minimum one weelky(QMRP0 or twice weekly (Facility manager) to ensure routine compliance. 11-15-07 In addition, the nutritionist will supply menu substitutions for all excluded foods/drinks by 11-15-07.	

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I 057	Continued From page 1 approximately 1.25 PM revealed that Resident #3 was allergic to tomatoes and tomatoes based products. Review of the facility's menu book on October 18, 2007 at approximately 1:30 PM revealed that there were no substitute menus for the staff to use when tomatoes or tomatoes based products where on the menu. In an interview with the House Manager it was acknowledged that the facility did not have substitute menus for Resident # 3. There was no evidence that the nutritionist provided the facility with substitute menus for Resident # 3.	I 057		
I 060	3502.18 MEAL SERVICE / DINING AREAS Perishable foods shall be stored at proper temperatures in order to conserve nutritive value. This Statute is not met as evidenced by: Based on observation and staff interview the facility failed to ensure that the primary refrigerator in the facility was operating at proper temperatures. The find includes: During the environmental walk-through on 10/18/07 revealed that refrigerator that stores extra foods on the thire level was found not be equipped with a thermometer.	I 060	3502.18 A thermometer was purchased for the (extra food) refrigerator on 10-19-07. The facility manager will check for it routinely during weekly environmental audits.	
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors.	I 090		

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I 090	Continued From page 2 This Statute is not met as evidenced by: Based on observation and staff interview, the GHMRP failed to maintain the facility in a safe,clean,orderly and sanitary manner. The findings include: Internal 1. Door knobs missing off of Client #2's closet 2. Carpet throughout the facility appeared to be dirty and stained. 3. The supply closet door was observed to be off the hinges and not secured. 4. Client #3's recliner sofa chair (right arm) located in his bedroom appeared to have a hole in it exposing the cotton and wood. Interview the House Manager indicated that Client #2 would be getting a new recliner chair soon. 5. Mold and Mildew was observed in the shower located on the first floor close to the kitchen. 6. Shower located upstairs shower head was extended from the wall. 7. There was clutter observed in the coat closet. (i.e. wheelchair and wheelchair accessories, hospital rail pad, etc.) External 1. Gutter located in the back of the house appeared to be full of debris and leaves.	I 090	3504.1 All of the repair/upkeep issues cited will be addressed 11-7-07. The facility manager will Audit the physical environment weekly and report all maintenance issues for follow up. 11-15-07	

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I 090	Continued From page 3 2. Paint chipping on the pole with the 4414 numbers located in front of the home. 3. The wood framing outside of Client #1's and #2's window appeared to be rotten. The paint was observed to chipping. 4. The paint appeared to be chipping around the side door. The wood framing appeared to be rotting. 5. The wooden fence around the home had many large holes in them. Part of the fence that was to be attached to the home was detached and leaning into the backyard. 6. The backside of the house appeared to have dirt built-up and debris.	I 090	**External** 1. Gutters were cleaned 10-18-07 2. Pole will be repaired by 11-20-07 3. Window (client #1 and #2 bedroom) will be replaced by 11-30-07. 4. The side door will be repalced by 11-30-07 5. The fence will be replaced by 11-30-07 6. The dirt/debris at the backside of the house was cleaned out 10-18-07.	
I 095	3504.6 HOUSEKEEPING Each poison and caustic agent shall be stored in a locked cabinet and shall be out of direct reach of each resident. This Statute is not met as evidenced by: Based on observation the GHMRP failed to lock caustic agents being stored. The finding includes: During the environmental walk-through on 10/18/07 revealed that caustic agents were being stored in the bathroom under the sinks unlocked upstairs on the third level. (i.e. Scrub bubbles and Lysol Spray)	I 095	3504.6 The cited items were relocated to a locked cabinet. 10-18-07 Staff will be retrained to ensure that such items are routinely stored in the locked cabinet after use. 11-30-07 The facility Manager will Audit compliance during routine weekly environmental audits. 11-15-07	

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I 203	Continued From page 4	I 203		
I 203	3509.3 PERSONNEL POLICIES Each supervisor shall discuss the contents of job descriptions with each employee at the beginning employment and at least annually thereafter. This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current job descriptions for all employees annually. The finding includes: Review of the personnel files conducted on October 17, 2007 at 2:20 PM, revealed that GHMRP failed to provide evidence of current signed job descriptions for ten direct care staff. [Staff #1, #2, #3, #4, #5 ,#6, #7, #8, #9 and #10].	I 203	3509.3 All staff will have received and signed updated job descriptions by 11-16-07. MTS is systematically tracking the anniversary dates for this item so as to ensure that staff sign new job descriptions on a routine, annual basis. 11-15-07.	
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the facility failed to ensure that all staff had current health certificates on file. The finding includes: Review of personnel records on October 18, 2007 at approximately 9:25 AM revealed no	I 206		

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I 206	Continued From page 5 documented evidence of current health certificates for the Primary Care Phyisican, Psychologist,Occupational Therapist, Nutritionist, Recreational Therapist, Pharmacist and Physical Therapist consultants. Further review revealed no documented evidence of current health certificates for six out of ten direct care staff. In an interview with the House Manager on October 18, 2007 at approximately 12:10PM it was acknowledged that the health certifications were not available during the survey. (Staff #1, #2, #3, #4, #5 and #6)	I 206	3509.6 All of the updated health certificates will be obtained by 11-30-07. MTS was aware of this issue Via internal audits and had notified staff and clinical professionals of their specific file deficiencies. Follow up is ongoing. 11-15-07.	
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility failed to effectively train staff to implement emergency measures for five of five residents in the facility. (Resident #1, #2, #3 and #4) The findings include: 1. The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for five of five residents in the facility as evidenced by: Interview with the House Manager on October 18, 2007 at approximately 10:00 AM revealed that all staff was not trained in CPR. Record review on October 18, 2007 at approximately 10:10 AM revealed that three out of ten staff did not have current CPR certifications. There was no	I 227		

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I 227	Continued From page 6 documented evidence that all direct care staff had CPR training and current CPR certifications. (Staff #2, #3 and #5) 2. The QMRP failed to ensure that all staff had been effectively trained to implement emergency measures for five of five residents in the facility as evidenced by: In an interview with the House Manager on October 18, 2007 at approximately 10:05 AM acknowledged that all staff was not trained in First Aid. Record review on June 25, 2007 at approximately 10:15 AM revealed that three out of ten staff did not have current First Aid certifications. There was no documented evidence that all direct care staff had First Aid training and current First Aid certifications. (Staff #2, #3 and #5)	I 227	All ten staff have current CPR certification and training including the three cited, but MTS has not yet received the cards from the training agent. The training was done in September 2007. MTS will obtain the cards by 11-30-07. A signature sheet and agenda are attached as proof of the training.	
I 379	3519.10 EMERGENCIES In addition to the reporting requirement in 3519.5, each GHMRP shall notify the Department of Health, Health Facilities Division of any other unusual incident or event which substantially interferes with a resident ' s health, welfare, living arrangement, well being or in any other way places the resident at risk. Such notification shall be made by telephone immediately and shall be followed up by written notification within twenty-four (24) hours or the next work day. This Statute is not met as evidenced by: Based on interview and record review, report incidents that pose a risk to client health or safety to governmental agencies, as required by DC regulation (22 DCMR Chapter 35 Section	I 379		

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I 379	Continued From page 7 3519.10). The findings include: 1. Review of an unusual incident report dated 3/21/07 on 10/16/07 at approximately 9:05 AM revealed that Resident #2 had a seizure while sitting in her wheelchair at the day program. Further review of the incident revealed the client dropped her head an injured her right eyebrow and was taken to the emergency room. The client was diagnosed with an abrasion to the eyelid and contusion to the right eye. There was no documented evidence that this incident had been reported to governmental agencies as required. 2. Review of an unusual incident report dated February 5, 2007 on October 16, 2007 at approximately 9:05 AM revealed that Resident #1 was transported to the hospital emergency room for vomiting coffee ground material and was subsequently admitted for gastric intestinal bleeding. There was no evidence that this incident was reported to the DOH until February 12, 2007. 3. Review of an unusual incident report dated February 28, 2007 on October 16, 2007 at approximately 9:15 AM revealed that Resident #3 was transported to the hospital emergency room for evaluation of a superficial burn on the right side of his neck. There was no evidence that this incident was reported to the DOH until February 4, 2007.	I 379	1. The day program involved does not routinely send incident reports to MTS or any other residential providers. They say their obligation is to send such reports to the DDS case manager. MTS will meet with the day program to ensure that the program agrees to send such incident reports to the MTS home within 24 hours, so that it can be submitted to DOH and filed by MTS or that they send them to DOH and MTS in addition to DDS case manager. MTS will involve DDS case manager to ensure an agreement is reached. 2. The facility failed to send the incident report for client #1 to the IMC in a timely manner in this case. The QMRP will retrain all staff to ensure that each understands that incident reports must be sent to the IMC by the end of the shift on which the incident occurs. 3. See response for #2 above.	
I 401	3520.3 PROFESSION SERVICES: GENERAL PROVISIONS	I 401		

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I 401	Continued From page 8 Professional services shall include both diagnosis and evaluation, including identification of developmental levels and needs, treatment services, and services designed to prevent deterioration or further loss of function by the resident. This Statute is not met as evidenced by: Based on record review and staff interview, the facility failed to ensure the provision of a recommended speech and language assessment for two of four residents in the sample. (Resident #1 and #4) The finding includes: 1. Breakfast observation on October 16, 2007 at approximately 6:40 AM, revealed that Resident # 1was observed eating her food with a left handed curved built-up spoon at a fast pace . Staff verbally prompted the client to slow down and the client complied by slowing down her eating pace. Review of Resident #1's physicians's orders dated September 28, 2007 at approximately 11:45 AM on October 17, 2007 revealed that she has a diagnosis of spastic quadriplegia. Medical record review on October 17, 2007 at approximately 11:50 AM revealed that Resident #1 did not have a speech/ language assessment. In an interview with the Qualified Mental Retardation Professional (QMRP) on October 17, 2007 at 11:55 AM it was acknowledged that Resident #1 did not have a speech/ language assessment. There was no documented evidence that the client had been assessed by the speech/ language therapist. 2. Review of an undated investigative report on October 16, 2007 at approximately 9:25 AM revealed that on June 1, 2007, Resident # 4 was	I 401	1. Client #1 does have a speech assessment that was filed under speech Assessment that was filed under "Speech Pathology" in the ISP book. (see attached copy)	

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	09G183	A. BUILDING _____ B. WING _____	10/18/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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I 401	Continued From page 9 transported to the hospital emergency room and admitted for right lower lobe pneumonia and discharged on June 4, 2007. Further review revealed a recommendation for Resident # 4 to be evaluated by the speech/ language therapist to rule out dysphasia and associated aspiration of food, thin liquids and salvia. In an interview with the QMRP on October 17, 2007 at 3:55 PM it was acknowledged that Resident #4 did not have a speech/ language assessment completed. There was no documented evidence that the client had been assessed by the speech/ language therapist.	I 401	2. Client #4 is scheduled to have a swallowing study done on 11-12-07. Client #1 is also scheduled for a swallow study on 11-09-07. The dysphasia issue will be addressed at that time.	
I 422	3521.3 HABILITATION AND TRAINING Each GHMRP shall provide habilitation, training and assistance to residents in accordance with the resident ' s Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and record review, the facility's Qualified Mental Retardation Professional (QMRP) failed to integrate, coordinate and monitor its clients active treatment programs. The findings include: 1. The QMRP failed to ensure that Resident #1 was provided a plate riser as recommended by the Occupational Therapist (OT) as evidenced by: Breakfast observation on October 16, 2007 at approximately 6:40 AM, revealed that the staff placed three divided plates on top of each other in order to elevate Resident #1's plate. Interview with direct care staff on October 16, 2007 at approximately 6:50 AM, revealed that Resident	I 422	Client #1's plate Riser will be obtained by 11-15-07. The QMRP will develop a checklist of the recommendations accepted by the team from each clinical service and for each person supported. This checklist will be used to track recommendations and ensure all are properly implemented.	

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I 422	Continued From page 10 #1 did not have a plate riser. Review of the OT assessment dated January 10, 2007 on October 17, 2007 at approximately 1:15 PM, revealed that Resident #1 was to be provided a plate riser to modify her feeding environment and increase overall independence in self feeding. There was no evidence that a plate riser was provided as recommended by the OT. 2. The QMRP failed to ensure that Resident #1 was provided adult hobby materials as recommended by the Psychologist as evidenced by: Evening observation on October 16, 2007 at approximately 4:45 PM, revealed that the staff assisted Resident #1 in playing with a child age key board. Review of the psychological assessment dated June 10, 2007 on October 17, 2007 at approximately 12:10PM, revealed that Resident #1 was to be provided adult hobby materials that made noise. In an interview with the QMRP on October 17, 2007 at approximately 1:20 PM it was acknowledged that Resident #1 did not have adult hobby materials that made noise . There was no evidence that adult hobby materials that made noise were provided as recommended by the Psychologist . [Note: The QMRP brought adult hobby materials for Resident #1 on October 18, 2007]	I 422	See Response for #7 above. In addition, the QMRP will ensure that adult hobby materials are replenished as needed.	
I 424	3521.5(a) HABILITATION AND TRAINING Each GHMRP shall make modifications to the resident ' s program at least every six (6) months or when the client: (a) Has successfully completed an objective or objectives identified in the Individual Habilitation	I 424		

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I 424	Continued From page 11 Plan: This Statute is not met as evidenced by: Based on record review, the Qualified Mental Retardation Professional (QMRP) failed to revise objectives identified in the individual program plans (IPPs)as they had been successfully achieved for one of four residents included the sample. (Resident #2) The finding includes: Review of the Resident #2's Individual Program Plans (IPP)s and related data collection was reviewed on 10/18/07 at approximately 8:44 AM. There were no revisions made to the program that had been achieved at the stated criterion level as evidenced below: Resident #2's IPP indicated that the client will tolerate ten (10) repetitions of shoulder/elbow passive Range of Motion (ROM) on 80% of the trials recorded per month for 3 consecutive months. The documentation reflected that from June 2007 to September 2007, the client performed at tasks above 80% . Interviews with the Qualified Mental Retardation Professional (QMRP) on 10/18/07 at approximately 11:49 AM acknowledged that the resident had achieved the objective according to the stated criterion. There was no document evidence that the QMRP discontinued the program after the criterion was met.	I 424	Client #2 achieved the cited objective in September of 2007. The QMRP discontinued the program at that time. However, as is often done, the QMRP had staff collect data for another month (October) to ensure that the skill level achieved was retained. It was. Data collection was totally discontinued as of November 2007. Client #2 continues to perform the task as a structured activity.	
I 443	3521.7(m) HABILITATION AND TRAINING The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas:	I 443		

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I 443	Continued From page 12 (m) Financial management (including budgeting and banking); This Statute is not met as evidenced by: Based on staff interview and record review the Group Home for Mentally Retarded Person (GHMRP) failed to ensure the habilitation and skill building of residents as required by this section. (Resident #1 and #2) The finding includes: 1. Review of Resident #1's Individual Program Plan (IPP) dated October 2007, on October 17, 2007 at approximately 1:50 PM included the following money management objectives: a. Select an item b. Take item to the cashier c. Pay for item e. Wait for the change/receipt f. Say thank you Further review of the objectives indicated that the staff was instructed to document a (+) for accomplished if all five objectives were completed and (-) if all five objectives were not met or refused In an interview with the Qualified Mental Retardation Professional (QMRP) on October 18, 2007 at approximately 2:00PM it was acknowledged that the program had multiple criteria for mastery and was not measurable. There was no evidence that the measurement criteria provided measurable indices of performance at each level. 2. Review of Client #3's Individual Program Plan (IPP) dated 8/20/0, on October 18, 2007 at	I 443	W231 The QMRP did not acknowledge that the money management objective for client #1 and #3 "had multiple criteria for mastery and was not measurable." To the contrary, the QMRP does not agree client #1's measurable objective in the money management area is, "_____will make a small purchase in the community once a month for six months consecutive months." That objective is measurable. Items "a" through "f" referred to by the surveyor are the functional steps that must be completed to successfully complete the task. The surveyor seems to be confusing "multiple criteria for mastery" with task analysis breakdown. Plus (+) or (-) is used as opposed to levels of assistance (Physical, gestural, verbal, Independent) because the QMRP and IDT recognizes that client #1 will always need physical assistance to make a purchase, along with one-on-one staff support and guidance. The objective then aims to measure her level of participation and coorperation. Staff is instructed to score plus(+) if she -Accepts assistance -Follows instructions -coorperates/participates fully. For each step and minus (-) if she does not, staff understand this fully and explained it to the monitor when asked. Client #3's objective is also measurable, " . . will make a small purchase of no more than one dollar from his personal funds given no more than 3 verbal cues from staff on 6 consecutive opportunities presented." Again there are task analyzed steps but in this case, the level of assistance is measured:	

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I 443	Continued From page 13 approximately 9:36 AM included the following money management objective: a. Select an item b. Take item to the cashier c. Pay for item e. Wait for the change/receipt f. Say thank you Further review of the objectives indicated that the staff was instructed to document a (+) for accomplished if all five objectives were completed and (-) if all five objectives were not met or refused. In an interview with the Qualified Mental Retardation Professional (QMRP) on October 18, 2007 at approximately 2:00 PM it was acknowledged that the program had multiple criteria for mastery and was not measurable. There was no evidence that the measurement criteria provided measurable indices of performance at each level.	I 443	A - needed hands on assistance R Verbal Reminder X= Given opportunity did not perform G= gestural assistance I= Independence In october, client #3 performed at the "A" level for all steps.(Needed hands on assistance). The QA consultant will meet with the QMRP to review these programs and those cited under W237 to insure that they are clearly stated in measurable terms, and data collection system and task analysis reflect the measurable objective and that there are clear protocols for staff to follow that explain all of the above.	

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R 000	INITIAL COMMENTS Based on interview and record review, the facility failed to ensure that all staff had police clearances on file. The finding includes: Review of ten personnel records on October 18, 2007 at approximately 2:10 PM revealed no documented evidence of a police clearance for one staff members. (Staff #1)	R 000	R000 Staff #2 has a police clearance. (see attached Copy) 11-1-07	

Health Regulation Administration

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE